Senate Bill No. 1847

CHAPTER 405

An act to amend Sections 789.8, 791.13, 1060, 1749.85, 1872.83, 1874.8, 10089.83, 12922, 12961, 12962, and 12967 of, to amend and renumber Section 10133.66 of, and to repeal Sections 742.435 and 1751.8 of, the Insurance Code, relating to insurance, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 22, 2006. Filed with Secretary of State September 22, 2006.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1847, Committee on Banking, Finance and Insurance. Insurance: privacy.

Under current law the Insurance Commissioner investigates certain matters and makes reports to the Legislature by 2001 and 2002.

This bill would repeal those provisions.

Under existing law, if a life agent offers to sell an elder any life insurance or annuity product, the agent must provide a written disclosure, as specified, to the elder.

This bill would add disclosure language, as specified, regarding the Medi-Cal Recovery Program, which may apply to annuities purchased after September 1, 2004.

Under existing law an insurance institution, agent, or insurance-support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure comes within specified exceptions generally designed to facilitate the legitimate transaction of insurance.

This bill would add an exception to the general rule of nondisclosure when the disclosure is to an insured when the information disclosed is from an accident report, supplemental report, investigative report or the actual report from a government agency or is an exact copy of an accident report or other report which the insured is entitled to obtain under other specified provisions of law.

Existing law requires the Insurance Commissioner and the Department of Insurance to submit various reports to the Governor and the Legislature. Existing law also requires the Insurance Commissioner to submit an annual report to the Governor.

This bill would require, instead, that the information required in those various reports be provided in the commissioner's annual report to the Governor which would also be provided to the Legislature and to the committees of the Senate and Assembly having jurisdiction over insurance.

Existing law requires certain persons to receive instruction in proper methods for estimating the replacement value of structures and provides that others shall not estimate the replacement value of a structure.

This bill would specifically provide that these provisions shall not be construed to preclude licensed appraisers, contractors, and architects from estimating the replacement value of a structure, as specified.

This bill would declare that it is to take effect immediately as an urgency statute. However, only the provisions relating to estimating the replacement value of structures would become operative immediately. The remainder would become operative January 1, 2007.

The people of the State of California do enact as follows:

SECTION 1. Section 742.435 of the Insurance Code is repealed.

SEC. 1.5. Section 789.8 of the Insurance Code is amended to read:

789.8. (a) "Elder" for purposes of this section means any person residing in this state who is 65 years of age or older.

(b) If a life agent offers to sell to an elder any life insurance or annuity product, the life agent shall advise an elder or elder's agent in writing that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation, and that the elder or elder's agent may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale, or sold. This section does not apply to a credit life insurance product as defined in Section 779.2.

(c) A life agent who offers for sale or sells a financial product to an elder on the basis of the product's treatment under the Medi-Cal program may not negligently misrepresent the treatment of any asset under the statutes and rules and regulations of the Medi-Cal program, as it pertains to the determination of the elder's eligibility for any program of public assistance.

(d) A life agent who offers for sale or sells any financial product on the basis of its treatment under the Medi-Cal program shall provide, in writing, the following disclosure to the elder or the elder's agent:

"NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

If you or your spouse are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

RECOVERY

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

UNMARRIED RESIDENT

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than (insert amount of individual's resource allowance) in countable resources.

The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of (insert amount of personal needs allowance) plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

MARRIED RESIDENT

COMMUNITY SPOUSE RESOURCE ALLOWANCE: If one spouse lives in a nursing facility, and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than (insert amount of community countable assets).

MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income or (insert amount of the minimum monthly maintenance needs allowance), whichever is greater.

FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than (insert amount of community spouse resource allowance plus individual's resource allowance) in countable resources. The order also may allow the at-home spouse to retain more than (insert amount of the monthly maintenance needs allowance) in monthly income.

REAL AND PERSONAL PROPERTY EXEMPTIONS

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

REAL PROPERTY EXEMPTIONS

ONE PRINCIPAL RESIDENCE: One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.

The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

REAL PROPERTY USED IN A BUSINESS OR TRADE: Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

PERSONAL PROPERTY AND OTHER EXEMPT ASSETS

IRAs, KEOGHs, AND OTHER WORK-RELATED PENSION PLANS: These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.

PERSONAL PROPERTY USED IN A TRADE OR BUSINESS.

ONE MOTOR VEHICLE.

IRREVOCABLE BURIAL TRUSTS OR IRREVOCABLE PREPAID BURIAL CONTRACTS.

THERE MAY BE OTHER ASSETS THAT MAY BE EXEMPT.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney who is not connected with the sale of this product.

I have read the above notice and have received a copy.

Dated: _____ Signature: _____"

The statement required in this subdivision shall be printed in at least 12-point type, shall be clearly separate from any other document or writing, and shall be signed by the prospective purchaser and that person's spouse, and legal representative, if any.

(e) The State Department of Health Services shall update this form to ensure consistency with state and federal law and make the disclosure available to agents and brokers through its Internet Web site.

(f) Nothing in this section allows or is intended to allow the unlawful practice of law.

(g) Subdivisions (b) and (d) shall become operative on July 1, 2001.

SEC. 2. Section 791.13 of the Insurance Code is amended to read:

791.13. An insurance institution, agent, or insurance-support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is:

(a) With the written authorization of the individual, and meets either of the conditions specified in paragraph (1) or (2):

(1) If such authorization is submitted by another insurance institution, agent, or insurance-support organization, the authorization meets the requirement of Section 791.06.

(2) If such authorization is submitted by a person other than an insurance institution, agent, or insurance-support organization, the authorization is:

(A) Dated.

(B) Signed by the individual.

(C) Obtained one year or less prior to the date a disclosure is sought pursuant to this section.

(b) To a person other than an insurance institution, agent, or insurance-support organization, provided such disclosure is reasonably necessary:

(1) To enable such person to perform a business, professional or insurance function for the disclosing insurance institution, agent, or insurance-support organization or insured and such person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

(A) Would otherwise be permitted by this section if made by an insurance institution, agent, or insurance-support organization; or

(B) Is reasonably necessary for such person to perform its function for the disclosing insurance institution, agent, or insurance-support organization.

(2) To enable such person to provide information to the disclosing insurance institution, agent or insurance-support organization for the purpose of:

(A) Determining an individual's eligibility for an insurance benefit or payment; or

(B) Detecting or preventing criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction.

(c) To an insurance institution, agent, insurance-support organization or self-insurer, provided the information disclosed is limited to that which is reasonably necessary under either paragraph (1) or (2):

(1) To detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with insurance transactions; or

(2) For either the disclosing or receiving insurance institution, agent or insurance-support organization to perform its function in connection with an insurance transaction involving the individual.

(d) To a medical-care institution or medical professional for the purpose of any of the following:

(1) Verifying insurance coverage or benefits.

(2) Informing an individual of a medical problem of which the individual may not be aware.

(3) Conducting operations or services audit, provided only such information is disclosed as is reasonably necessary to accomplish the foregoing purposes.

(e) To an insurance regulatory authority; or

(f) To a law enforcement or other governmental authority pursuant to law.

(g) Otherwise permitted or required by law.

(h) In response to a facially valid administrative or judicial order, including a search warrant or subpoena.

(i) Made for the purpose of conducting actuarial or research studies, provided:

(1) No individual may be identified in any actuarial or research report.

(2) Materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed.

(3) The actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent or insurance-support organization.

(j) To a party or a representative of a party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurance institution, agent or insurance-support organization, provided:

(1) Prior to the consummation of the sale, transfer, merger, or consolidation only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger, or consolidation.

(2) The recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance institution, agent or insurance-support organization.

(k) To a person whose only use of such information will be in connection with the marketing of a product or service, provided:

(1) No medical-record information, privileged information, or personal information relating to an individual's character, personal habits, mode of living, or general reputation is disclosed, and no classification derived from such information is disclosed; or

(2) The individual has been given an opportunity to indicate that he or she does not want personal information disclosed for marketing purposes and has given no indication that he or she does not want the information disclosed; and

(3) The person receiving such information agrees not to use it except in connection with the marketing of a product or service.

(*l*) To an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons.

(m) By a consumer reporting agency, provided the disclosure is to a person other than an insurance institution or agent.

(n) To a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit.

(o) To a professional peer review organization for the purpose of reviewing the service or conduct of a medical-care institution or medical professional.

(p) To a governmental authority for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable.

(q) To a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction.

(r) To a lienholder, mortgagee, assignee, lessor, or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of insurance. The information disclosed shall be limited to that which is reasonably necessary to permit the person to protect his or her interest in the policy and shall be consistent with Article 5.5 (commencing with Section 770).

(s) To an insured when the information disclosed is from an accident report, supplemental report, investigative report or the actual report from a government agency or is a copy of an accident report or other report which the insured is entitled to obtain under Section 20012 of the Vehicle Code or subdivision (f) of Section 6254 of the Government Code.

SEC. 3. Section 1060 of the Insurance Code is amended to read:

1060. The commissioner shall transmit all of the following to the Governor, the Legislature, and to the committees of the Senate and Assembly having jurisdiction over insurance in the annual report submitted pursuant to Section 12922:

(a) The names of the persons proceeded against under this article.

(b) Whether such persons have resumed business or have been liquidated or have been mutualized.

(c) Such other facts as will acquaint the Governor, the policyholders, creditors, shareholders and the public with his or her proceedings under this article.

SEC. 4. Section 1749.85 of the Insurance Code is amended to read:

1749.85. (a) The curriculum committee shall, in 2006, make recommendations to the commissioner to instruct fire and casualty broker-agents and personal lines broker-agents and applicants for fire and casualty broker-agent and personal lines broker-agent licenses in proper methods of estimating the replacement value of structures, and of explaining various levels of coverage under a homeowners' insurance policy. Each provider of courses based upon this curriculum shall submit its course content to the commissioner for approval.

(b) A person who is not an insurer underwriter or actuary or other person identified by the insurer, or a licensed fire and casualty broker-agent, personal lines broker-agent, contractor, or architect shall not estimate the replacement value of a structure, or explain various levels of coverage under a homeowners' insurance policy.

(c) This section shall not be construed to preclude licensed appraisers, contractors and architects from estimating replacement value of a structure.

(d) However, if the Department of Insurance, by adopting a regulation, establishes standards for the calculation of estimates of replacement value of a structure by appraisers, then on and after the effective date of the regulation a real estate appraiser's estimate of replacement value shall be calculated in accordance with the regulation.

SEC. 5. Section 1751.8 of the Insurance Code is repealed.

SEC. 6. Section 1872.83 of the Insurance Code is amended to read:

1872.83. (a) The commissioner shall ensure that the Fraud Division aggressively pursues all reported incidents of probable workers' compensation fraud, as defined in Sections 11760 and 11880,and in subdivision (a) of Section 1871.4, and in Section 549 of the Penal Code, and forwards to the appropriate disciplinary body the names, along with all supporting evidence, of any individuals licensed under the Business and Professions Code who are suspected of actively engaging in fraudulent activity. The Fraud Division shall forward to the Insurance Commissioner or the Director of Industrial Relations, as appropriate, the name, along with all supporting evidence, of any insurer, as defined in subdivision (c) of Section 1877.1, suspected of actively engaging in the fraudulent denial of claims.

(b) To fund increased investigation and prosecution of workers' compensation fraud, and of willful failure to secure payment of workers' compensation, in violation of Section 3700.5 of the Labor Code, there shall be an annual assessment as follows:

(1) The aggregate amount of the assessment shall be determined by the Fraud Assessment Commission, which is hereby established. The commission shall be composed of seven members consisting of two representatives of organized labor, two representatives of self-insured employers, one representative of insured employers, one representative of workers' compensation insurers, and the President of the State Compensation Insurance Fund, or his or her designee.

The Governor shall appoint members representing organized labor, self-insured employers, insured employers, and insurers. The term of office of members of the commission shall be four years, and a member shall hold office until the appointment of a successor. The President of the State Compensation Insurance Fund shall be an ex officio, voting member of the commission. Members of the commission shall receive one hundred dollars ($100) for each day of actual attendance at commission meetings and other official commission business, and shall also receive their actual and necessary traveling expenses incurred in the performance of commission duties. Payment of per diem and travel expenses shall be made from the Workers' Compensation Fraud Account in the Insurance Fund, established in paragraph (4), upon appropriation by the Legislature.

(2) In determining the aggregate amount of the assessment, the Fraud Assessment Commission shall consider the advice and recommendations of the Fraud Division and the commissioner.

(3) The aggregate amount of the assessment shall be collected by the Director of Industrial Relations pursuant to Section 62.6 of the Labor Code. The Fraud Assessment Commission shall annually advise the Director of Industrial Relations, not later than March 15, of the aggregate amount to be assessed for the next fiscal year.

(4) The amount collected, together with the fines collected for violations of the unlawful acts specified in Sections 1871.4, 11760, and 11880, Section 3700.5 of the Labor Code, and Section 549 of the Penal Code, shall be deposited in the Workers' Compensation Fraud Account in the Insurance Fund, which is hereby created, and may be used, upon appropriation by the Legislature, only for enhanced investigation and prosecution of workers' compensation fraud and of willful failure to secure payment of workers' compensation as provided in this section.

(c) For each fiscal year, the total amount of revenues derived from the assessment pursuant to subdivision (b) shall, together with amounts collected pursuant to fines imposed for unlawful acts described in Sections 1871.4, 11760, and 11880, Section 3700.5 of the Labor Code, and Section 549 of the Penal Code, not be less than three million dollars ($3,000,000). Any funds appropriated by the Legislature pursuant to subdivision (b) that are not expended in the fiscal year for which they have been appropriated, and that have not been allocated under subdivision (f), shall be applied to satisfy for the immediately following fiscal year the minimum total amount required by this subdivision. In no case may that money be transferred to the General Fund.

(d) After incidental expenses, at least 40 percent of the funds to be used for the purposes of this section shall be provided to the Fraud Division of the Department of Insurance for enhanced investigative efforts, and at least 40 percent of the funds shall be distributed to district attorneys, pursuant to a determination by the commissioner with the advice and consent of the division and the Fraud Assessment Commission, as to the most effective distribution of moneys for purposes of the investigation and prosecution of workers' compensation fraud cases and cases relating to the willful failure to secure the payment of workers' compensation. Each district attorney seeking a portion of the funds shall submit to the commissioner an application setting forth in detail the proposed use of any funds provided. A district attorney receiving funds pursuant to this subdivision shall submit an annual report to the commissioner with respect to the success of his or her efforts. Upon receipt, the commissioner shall provide copies to the Fraud Division and the Fraud Assessment Commission of any application, annual report, or other documents with respect to the allocation of money pursuant to this subdivision. Both the application for moneys and the distribution of moneys shall be public documents. Information submitted to the commissioner pursuant to this section concerning criminal investigations, whether active or inactive, shall be confidential.

(e) If a district attorney is determined by the commissioner to be unable or unwilling to investigate and prosecute workers' compensation fraud claims or claims relating to the willful failure to secure the payment of workers' compensation, the commissioner shall discontinue distribution of funds allocated for that county and may redistribute those funds according to this subdivision.

(1) The commissioner shall promptly determine whether any other county could assert jurisdiction to prosecute the fraud claims or claims relating to the willful failure to secure the payment of workers' compensation that would have been brought in the nonparticipating county, and if so, the commissioner may award funds to conduct the prosecutions redirected pursuant to this subdivision. These funds may be in addition to any other fraud prosecution funds or claims relating to the willful failure to secure the payment of workers' compensation prosecution otherwise awarded under this section. Any district attorney receiving funds pursuant to this subdivision shall first agree that the funds shall be used solely for investigating and prosecuting those cases of workers' compensation fraud or claims relating to the willful failure to secure the payment of workers' compensation that are redirected pursuant to this subdivision and submit an annual report to the commissioner with respect to the success of the district attorney's efforts. The commissioner shall keep the Fraud Assessment Commission fully informed of all reallocations of funds under this paragraph.

(2) If the commissioner determines that no district attorney is willing or able to investigate and prosecute the workers' compensation fraud claims or claims relating to the willful failure to secure the payment of workers'

compensation arising in the nonparticipating county, the commissioner, with the advice and consent of the Fraud Assessment Commission, may award to the Attorney General some or all of the funds previously awarded to the nonparticipating county. Before the commissioner may award any funds, the Attorney General shall submit to the commissioner an application setting forth in detail his or her proposed use of any funds provided and agreeing that any funds awarded shall be used solely for investigating and prosecuting those cases of workers' compensation fraud or claims relating to the willful failure to secure the payment of workers' compensation that are redirected pursuant to this subdivision. The Attorney General shall submit an annual report to the commissioner with respect to the success of the fraud prosecution efforts of his or her office.

(3) Neither the Attorney General nor any district attorney shall be required to relinquish control of any investigation or prosecution undertaken pursuant to this subdivision unless the commissioner determines that satisfactory progress is no longer being made on the case or the case has been abandoned.

(4) A county that has become a nonparticipating county due to the inability or unwillingness of its district attorney to investigate and prosecute workers' compensation fraud or the willful failure to secure the payment of workers' compensation shall not become eligible to receive funding under this section until it has submitted a new application that meets the requirements of subdivision (d) and the applicable regulations.

(f) If in any fiscal year the Fraud Division does not use all of the funds made available to it under subdivision (d), any remaining funds may be distributed to district attorneys pursuant to a determination by the commissioner in accordance with the same procedures set forth in subdivision (d).

(g) The commissioner shall adopt rules and regulations to implement this section in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Included in the rules and regulations shall be the criteria for redistributing funds to district attorneys and the Attorney General. The adoption of the rules and regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare.

(h) The department shall report to the Governor, the Legislature, to the committees of the Senate and Assembly having jurisdiction over insurance, and the Fraud Assessment Commission on the activities of the Fraud Division and district attorneys supported by the funds provided by this section in the annual report submitted pursuant to Section 12922.

The annual report shall include, but is not limited to, all of the following information for the department and each district attorney's office:

(1) All allocations, distributions, and expenditures of funds.

(2) The number of search warrants issued.

(3) The number of arrests and prosecutions, and the aggregate number of parties involved in each.

(4) The number of convictions and the names of all convicted fraud perpetrators.

(5) The estimated value of all assets frozen, penalties assessed, and restitutions made for each conviction.

(6) Any additional items necessary to fully inform the Fraud Assessment Commission and the Legislature of the fraud-fighting efforts financed through this section.

(i) In order to meet the requirements of subdivision (g), the department shall submit a biannual information request to those district attorneys who have applied for and received funding through the annual assessment process under this section.

(j) Assessments levied or collected to fight workers' compensation fraud and insurance fraud are not taxes. Those funds are entrusted to the state to fight fraud and the willful failure to secure the payment of workers' compensation by funding state and local investigation and prosecution efforts. Accordingly, any funds resulting from assessments, fees, penalties, fines, restitution, or recovery of costs of investigation and prosecution deposited in the Insurance Fund shall not be deemed "unexpended" funds for any purpose and, if remaining in that account at the end of any fiscal year, shall be applied as provided in subdivision (f) and to offset or augment subsequent years' program funding.

(k) The Bureau of State Audits shall evaluate the effectiveness of the efforts of the Fraud Assessment Commission, the Fraud Division, the Department of Insurance, and the Department of Industrial Relations, as well as local law enforcement agencies, including district attorneys, in identifying, investigating, and prosecuting workers' compensation fraud and the willful failure to secure payment of workers' compensation. The report shall specifically identify areas of deficiencies. Included in this report shall be recommendations on whether the current program provides the appropriate levels of accountability for those responsible for the allocation and expenditure of funds raised from the assessment provided in this section. The Bureau of State Audits shall submit a report to the Chairperson of the Senate Committee on Labor and Industrial Relations and the Chairperson of the Assembly Committee on Insurance on or before May 1, 2004.

SEC. 7. Section 1874.8 of the Insurance Code, as amended by Section 14 of Chapter 717 of the Statutes of 2005, is amended to read:

1874.8. (a) Each insurer doing business in this state shall pay an annual fee to be determined by the commissioner, but not to exceed fifty cents ($0.50) annually for each vehicle insured under an insurance policy it issues in this state, in order to fund the Fraud Division and an Organized Automobile Fraud Activity Interdiction Program. The commissioner shall award three to 10 grants for a coordinated program targeted at the successful prosecution and elimination of organized automobile fraud activity. The grants may only be awarded to district attorneys.

(b) In determining whether to award a district attorney a grant, the commissioner shall consider factors indicating organized automobile fraud activity in the district attorney's county, including, but not limited to, the county's level of general criminal activity, population density, automobile insurance claims frequency, number of suspected fraudulent claims, and prior and current evidence of organized automobile fraud activity. Funding priority shall be given to those grant applications with the potential to have the greatest impact on organized automobile insurance fraud activity.

(c) All participants of a grant referred to in subdivision (a) shall coordinate their efforts and work in conjunction with the bureau, other participating agencies, and all interested insurers in this regard. Of the funds collected pursuant to this section, 42.5 percent shall be distributed to district attorneys, 42.5 percent shall be distributed to the Fraud Division, and 15 percent shall be distributed to the Department of the California Highway Patrol. Funds distributed pursuant to this section to the Fraud Division and to the Department of the California Highway Patrol shall be used to fund bureau and Department of the California Highway Patrol investigators who shall be assigned to work solely in conjunction with district attorneys who are awarded grants. Each grantee shall be notified by the Fraud Division of the investigators assigned to work with the grantee. Nothing shall prohibit the referral of any cases developed by the Fraud Division to any appropriate prosecutorial entity.

(d) A grant under this section shall be awarded on the basis of a single application for a period of three years and shall be subject where applicable to the requirements of subdivision (b) of Section 1872.8, except for the requirement that grants be awarded according to population. Continued funding of a grant shall be contingent upon a grantee's successful performance as determined by an annual review by the commissioner. Any redirection of grant funds under this section shall be made only for good cause. The Department of the California Highway Patrol shall submit to the commissioner, for informational purposes only, an annual report on its expenditure of funds under this section in the same format as is required of grantees under this section.

(e) There shall be no prohibition against a joint application by two or more district attorneys for a grant award under this section.

(f) The Fraud Division shall report to the Governor, the Legislature, and to the committees of the Senate and Assembly having jurisdiction over insurance on the results of the grant program established by this section, including funding distributed to the Department of the California Highway Patrol in the annual report submitted pursuant to Section 12922.

(g) For purposes of this section, "organized automobile fraud activity" means two or more persons who conspire, aid and abet, or in any other manner act together, to engage in economic automobile theft as defined in subdivision (f) of Section 1872.8, or to violate any of the following provisions in relation to an automobile insurance claim:

(1) Section 650 or 6152 of the Business and Professions Code.

(2) Section 750 of the Insurance Code.

(3) Section 549, 550, or 551 of the Penal Code.

(h) This section shall remain in effect only until January 1, 2010, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2010, deletes or extends that date.

SEC. 8. Section 10089.83 of the Insurance Code is amended to read:

10089.83. (a) On or before August 1 of each year in which this program is in effect, the commissioner shall report to the Governor, the Legislature, and to the committees of the Senate and Assembly having jurisdiction over insurance on the status of the program in the prior year, including statistics about the number of cases suitable for mediation, the number sent to mediation, and the number accepted, as well as declined, by the insurers, and other similar information concerning the operation of the program in the annual report submitted pursuant to Section 12922.

(b) At six-month intervals, the department shall collect from the mediators with which it contracts for this service the following information: the number of persons to whom mediation was offered, the number of insurers that accepted and declined mediation, the number of settlements, and of those settlements, the number rejected within the three business day cooling off period. For each settlement, the mediation service shall also report the amount initially claimed by the consumer and the amount agreed to be paid, if any, by the insurer or other party.

(c) The department may adopt regulations, including reporting requirements, in the commissioner's discretion, to implement this chapter. The regulations shall be adopted as emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The adoption of the regulations is deemed necessary for the immediate preservation of the public peace, health or safety, or general welfare.

SEC. 9. Section 10133.66 of the Insurance Code, as added by Section 6 of Chapter 723 of the Statutes of 2005, is amended and renumbered to read:

10133.661. On or before July 1, 2006, the commissioner, pursuant to his or her authority under Section 12921.1, shall also complete all of the following duties:

(a) Provide announcements that inform health insurance consumers and their health care providers of the department's toll-free telephone number that is dedicated to the handling of complaints and of the availability of the Internet Web page established under this section, and the process to register a complaint with the department and to submit an inquiry to it.

(b) Establish an Internet Web page located on the department's public Internet Web site dedicated exclusively to processing complaints and inquiries relating to health insurance issues from insureds and their health care providers. The Web page shall provide insureds and their health care providers with information concerning filing a complaint and making an inquiry concerning a health insurer and, at a minimum, shall provide the following information:

(1) The department's toll-free telephone number.

(2) A list of all health insurers licensed by the department.

(3) Educational and informational guides for health insurance consumers and health care providers describing their rights under this code. The guides shall be easy to read and understand and shall be made available to the public, including access on the department's Internet Web site.

(4) A separate, standardized complaint form for health care providers to file a complaint.

(c) An insured or health care provider may file a written complaint with the department with respect to the handling of a claim or other obligation under a health insurance policy by a health insurer or production agency, or with respect to the alleged misconduct by a health insurer or production agency. The commissioner shall notify the complainant of the receipt of the complaint within 10 business days of its receipt. The commissioner shall make a determination on the complaint within 60 calendar days of the date of its receipt, unless the commissioner, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the complaint. The commissioner shall notify the complainant of the final action taken on his or her complaint within 30 days of the final action. The notification shall include a summary explaining the commissioner's reasons for the final action.

SEC. 10. Section 12922 of the Insurance Code is amended to read:

12922. The commissioner shall, on or before the first day of August in each year, make a report to the Governor, the Legislature, and to the committees of the Senate and Assembly having jurisdiction over insurance containing a tabular statement and synopsis of the reports which have been filed in his or her office and showing, generally, the condition of the insurance business and interests in this state, and other matters concerning insurance. The report shall also contain a detailed verified statement, of the moneys and fees of office received by him or her, and for what purpose.

SEC. 11. Section 12961 of the Insurance Code is amended to read:

12961. (a) The commissioner shall provide to the Governor, the Legislature, and to the committees of the Senate and Assembly having jurisdiction over insurance an analysis of the following types of actions in the annual report submitted pursuant to Section 12922:

(1) Medical malpractice actions.

(2) Toxic substance tort actions.

(3) Product and design liability actions.

(4) Tort actions in which a public entity is a defendant.

(5) Tort actions involving judgments or settlements of one million dollars ($1,000,000) or more.

(6) Class action tort actions.

(7) Defamation and invasion of privacy actions.

(8) Other categories of tort actions involving commercial liability claims as the commissioner deems necessary.

(b) The study may exclude actions in which the only defendant is an individual sued in his or her private capacity. The study may exclude limited civil cases.

(c) If any of the information required to be provided by the parties is confidential under any other provision of law or pursuant to any court order, the commissioner shall keep that information confidential and shall limit its analysis of that information to aggregate data or other analyses which will not reveal the identity of the parties.

SEC. 12. Section 12962 of the Insurance Code is amended to read:

12962. The commissioner shall report to the Governor, the Legislature, and to the committees of the Senate and Assembly having jurisdiction over insurance all of the following in the annual report submitted pursuant to Section 12922:

(a) An analysis of the information required by Sections 674.5, 1857.7, 1857.9, 1864, 11555.2, and 12963, including, but not limited to, all of the following:

(1) An aggregate and an average for all insurers for each item of information required by these sections.

(2) The number of insurers reporting policies written for each class during the calendar year.

(3) For each class, the number of insurers reporting a combined loss ratio of 100 percent or more, and the number reporting a combined loss ratio of under 100 percent.

(4) An analysis of adjustments made to loss reserves for prior years.

(5) The change in any item required to be included by paragraphs (1) to (4), inclusive, from the immediately prior year.

(b) An analysis of the activities of the Department of Insurance in implementing the provisions of Proposition 103 on the November 8, 1988, general election ballot, as set forth in Article 10 (commencing with Section 1861.01) of Chapter 9 of Part 2 of Division 1.

(c) Recommendations and proposals, including suggested legislation, to protect consumers from arbitrary insurance rates and practices, to encourage a competitive insurance marketplace, to provide for an accountable Insurance Commissioner, and to ensure that insurance is fair, available, and affordable for all Californians.

(d) An analysis on the results of the program to reduce the number of uninsured motorists and the relationship to affordable private passenger vehicle liability insurance rates pursuant to Sections 4750.2 and 4750.4 of the Vehicle Code.

(e) The requirements of this section shall be satisfied if the analysis required by this section is included in the annual report to the Governor required by Section 12922, and a copy of that report is provided to the Legislature.

SEC. 13. Section 12967 of the Insurance Code is amended to read:

12967. (a) (1) The department shall develop and implement a coordinated approach to gather, review, and analyze the archives of insurers and other archives and records, using onsite teams and the

oversight committee, to provide for research and investigation into insurance policies, unpaid insurance claims, and related matters of victims of the Holocaust or of the Nazi-controlled German government or its allies, and the beneficiaries and heirs of those victims, and for losses arising from the activities of the Nazi-controlled German government or its allies for insurance policies issued before and during World War II by insurers who have affiliates or subsidiaries authorized to do business in California. Information compiled shall be placed in a centralized database for the retention of policy and claimant data, and the data shall be used to implement this section and Section 790.15.

(2) The department has an affirmative duty to play an independent role in representing the interests of Holocaust survivors where necessary, including the duty to carry out research, investigations, and advocacy. The department shall cooperate with, participate in, promote coordination with, and to the extent feasible and consistent with the purposes of this section, work jointly with the National Association of Insurance Commissioners and the international commission on Holocaust survivor claims or any other entity involved in the documentation, resolution, settlement, or distribution of insurance claims, including the documentation of unpaid claims and the distribution of proceeds, and the establishment and maintenance of a database to contain information relevant to claimants and documents and historical information. The department shall work to recover information and records that will strengthen the claims of California residents.

(3) The department shall employ insurance archaeologists, economists, attorneys, accountants, and other specialists, in this country and in Europe, to implement this section. The department shall work jointly with the National Association of Insurance Commissioners and other organizations for this purpose. The department's cooperation with other states shall be for the purpose of advancing survivors' claims while avoiding duplication of efforts, and shall be dependent upon contributions by other states.

(4) In order to assure that Holocaust survivors receive the most aggressive and independent representation possible in pursuit of their historic claims, in contracting with accounting firms, law firms, economists, or others to implement this section, the department shall, to the maximum extent possible, avoid any potential or actual conflict of interest by doing the following:

(A) Seek and give preference to firms that are entirely free of any associations with firms representing insurers and nations from which Holocaust survivors are seeking just treatment of their claims.

(B) If the department finds that it is necessary to contract with a firm or firms that have conflicts or potential conflicts of interest, those conflicts or potential conflicts of interest shall be disclosed to the commissioner, and the following requirements shall apply:

(i) The contract shall contain a provision that expresses a formal commitment on the part of the firm to aggressively pursue a maximum just settlement for Holocaust survivors and their families without regard to any

adverse impacts on insurers, affiliates of insurers, nations, or others that may have employed the firm or affiliates of the firm that is contracting with the commissioner to assist in carrying out the commissioner's responsibilities under this section.

(ii) If any conflict or potential conflict exists between the firm, or an affiliate of the firm, and an insurer, an affiliate of an insurer, a nation or others directly or indirectly involving Holocaust claims, the firm shall disclose both the fact of the conflict or potential conflict, and all relevant information describing the nature of the conflict or potential conflict.

(iii) If a conflict or potential conflict exists between the firm, or an affiliate of the firm, and an insurer, an affiliate of an insurer, a nation, or others that does not directly or indirectly involve Holocaust claims, the firm shall disclose the fact of the conflict or potential conflict and identify the source of the conflict or potential conflict, but need not describe the particular circumstances or facts that create the conflict or potential conflict.

(C) The department may take whatever special measures it deems necessary to avoid either the appearance or the reality of conflicts that may undermine public confidence in the integrity of the effort to secure justice for Holocaust survivors.

(b) The funding of the activities provided for by this section for the 1998–99 fiscal year shall be from funds transferred pursuant to subdivision (b) of Section 1523 of the Code of Civil Procedure, which funds are hereby appropriated to the commissioner for that purpose. The commissioner shall seek reimbursement of those funds as provided in subdivision (c).

Funding for subsequent fiscal years shall be subject to the Budget Act and based on a plan submitted by the commissioner to the Legislature outlining the plan for reimbursement of expenses of the department by affected insurers.

Funds made available to implement this section shall be used to develop and implement a coordinated approach to gather, review, and analyze the archives of affected insurance groups, and other archives and records, using onsite teams and the oversight committee. These funds shall also be used to fund the necessary expenses of the Holocaust Era Insurance Claims Oversight Committee established in subdivision (d). The information compiled shall be placed in a centralized database for the retention of policy and claimant data, and that data shall be used by the department to implement this section.

(c) (1) Any funds recovered by the department for the purpose of reimbursing the state for costs associated with investigation and enforcement actions under this section shall not be deposited in the Insurance Fund, but instead shall be delivered to the Controller for deposit into the General Fund.

(2) To the maximum extent possible, the department shall seek reimbursement for its costs incurred in implementing this section, including funds transferred pursuant to subdivision (b) of Section 1523 of

the Code of Civil Procedure, from any settlements reached with affected insurers.

(d) (1) There is established a seven-member Holocaust Era Insurance Claims Oversight Committee, that shall be known as the oversight committee, and whose members shall be appointed as follows:

(A) Four members shall be appointed by the Governor.

(B) One member shall be appointed by the President pro Tempore of the Senate.

(C) One member shall be appointed by the Speaker of the Assembly.

(D) One member shall be appointed by the Commissioner of Insurance.

(2) The Governor shall designate one of his or her appointees as the chairperson of the committee.

(3) Each member of the committee shall serve at the pleasure of the authority that appointed him or her to serve on the committee.

(4) The oversight committee shall be composed of qualified individuals with experience in Holocaust claims cases, similar investigations, archival research, and international law. The oversight committee shall also include Holocaust survivors. No member of the oversight committee shall have a potential or actual conflict of interest, or shall be employed by a person who has a potential or actual conflict of interest.

(5) The appointments shall be expedited because of the urgency due to survivors' needs.

(6) The oversight committee shall have the following authority and shall do all of the following:

(A) Review and make recommendations concerning any insurance settlement negotiation or offer relating to a Holocaust era insurance claim in which the department is involved.

(B) Review and make recommendations to the commissioner on the priorities for expenditure of funds and use of resources by the department for Holocaust era insurance claims related activities.

(C) Recommend whether a proposed settlement of a Holocaust era insurance claim submitted to the committee pursuant to paragraph (7) is equitable before the department finalizes the settlement agreement.

(7) The commissioner, in the event of a proposed settlement of any policy or group of policies relating to Holocaust era insurance claims, shall confer with the committee prior to the department finalizing the settlement agreement. The department may not finalize a proposed settlement of a Holocaust era insurance claim unless the committee, pursuant to subparagraph (C) of paragraph (6), recommends that the proposed settlement is equitable.

(e) The department shall report its progress in implementing this section and its participation in the identification and resolution of insurance claims of Holocaust survivors and their beneficiaries and heirs. The report shall also include an overview of current and anticipated expenditures in implementing this section. The department shall report this information to the Governor, the Legislature, and the insurance and budget

committees of the Legislature in the annual report submitted pursuant to Section 12922.

SEC. 14. Notwithstanding Section 15 of this bill, Sections 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, and 13 shall not become operative until January 1, 2007.

SEC. 15. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to clarify existing provisions of law concerning persons who are permitted to estimate replacement values of a structure, it is necessary that these provisions go into immediate effect.

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